

# Appendix 3

## Sample HCFA 1500 Claim Form-Physician Anesthesia Services

HEALTH INSURANCE CLAIM FORM										PICA
<div style="display: flex; justify-content: space-between;"> <div> <div> <div>1. MEDICARE</div> <div>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>3. PATIENT'S BIRTH DATE</div> <div>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>5. PATIENT'S ADDRESS (No., Street)</div> <div>6. PATIENT RELATIONSHIP TO INSURED</div> <div>7. INSURED'S ADDRESS (No., Street)</div> <div>8. PATIENT STATUS</div> <div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>11. INSURED'S POLICY GROUP OR FECA NUMBER</div> <div>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</div> <div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div> </div> <div> <div> <div>14. DATE OF CURRENT:</div> <div>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</div> <div>17a. I.D. NUMBER OF REFERRING PHYSICIAN</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div>19. RESERVED FOR LOCAL USE</div> <div>20. OUTSIDE LAB?</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)</div> <div>22. MEDICAID RESUBMISSION CODE</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> </div> <div> <div>24. A. DATE(S) OF SERVICE</div> <div>24. B. PLACE OF SERVICE</div> <div>24. C. TYPE OF SERVICE</div> <div>24. D. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS)</div> <div>24. E. DIAGNOSIS CODE</div> <div>24. F. \$ CHARGES</div> <div>24. G. DAYS OR UNITS</div> <div>24. H. EPSDT Family Plan</div> <div>24. I. EMG</div> <div>24. J. COB</div> <div>24. K. RESERVED FOR LOCAL USE</div> </div> </div> </div> </div>										